SURGICAL ASSOCIATES of marquette, pc

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Phone 906-225-3853 * Fax 906-228-4065

Name: Last _____ **First** _____ **MI** _____

Birthdate: _____ **SEX:** F M **Age:** _____ **Height:** _____ **Weight:** _____

Primary Dr: _____ **Cardiologist:** _____

HEART / CIRCULATION	YES	NO	COMMENTS
Angina (Chest Pain)			
Heart Failure (fluid in lungs)			
History of Heart Attack			
Heart Valve Disorder/Replacement			
Have a Pacemaker			
Have a Defibrillator			
Hypertension (High Blood Pressure)			
Do you take a anticoagulation medication?			
Have you had an EKG in the last 6 months?			If yes, Where:

RESPIRATORY	YES	NO	COMMENTS
Emphysema/COPD			
Pneumonia (within last 2 months)			
Asthma			
Sleep Apnea			
Any other respiratory problems?			

STOMACH/INTESTINAL	YES	NO	COMMENTS
Heartburn/Reflux			
Ulcers or History of Ulcers			
Colitis or Diverticulitis			
Any other stomach or intestinal problems?			

LIVER	YES	NO	COMMENTS
Hepatitis			
Recent Jaundice			
Cirrhosis			
Any other liver problems?			

KIDNEY/BLADDER	YES	NO	COMMENTS
Bladder Problems			
Kidney Disorder			
Kidney Transplant or removal			
Dialysis Patient			
Any other kidney or bladder problems?			

NEUROLOGIC	YES	NO	COMMENTS
Seizure/Epilepsy			
Stroke			
Multiple Sclerosis or Muscle Problems			
Head Injury			
Migraines/Headaches			
Any other neurological problems?			

ALLERGIES – Medications: To What	Reactions	Are you allergic to any of the following:		
		Latex	YES	NO
		Contrast Dye	YES	NO
		IVP Dye	YES	NO

GENERAL	YES	NO	COMMENTS
Arthritis			
Diabetes			Type: How many years?
Cancer			If YES, What type:
Bleeding Disorder			
Recent Infections			
Chronic Pain Problems			
Could you be pregnant?			Last Menstrual Period:
Smoking History			How much? How long? When quit?
Influenza Vaccination last year			
Pneumovax Vaccination in last 8 years			
Exposure to or ever have TB/HIV/AIDS/MRSA/VRE			
Psychiatric Disorder/Emotional Problems			
Drug/Alcohol Problems or Treatment			
Religious Restrictions to Medical Care			

MEDICATIONS NAME	DOSAGE	NAME	DOSAGE

SURGICAL HISTORY (PLEASE LIST)		
Have you had a joint replacement surgery	YES	NO
Problems with pain control after surgery	YES	NO
Problems with anesthesia	YES	NO
Unexplained fever after surgery	YES	NO

FAMILY HISTORY	YES	NO	COMMENTS
Neurological – Stroke/Seizure			
Heart Problems			
High Blood Pressure			
Cancer			
Anesthetic Problems			

How would you like to receive test results? ☐ Phone ☐ Mail *Please note routine pre-operative laboratory testing such as blood work, chest x-ray and/or EKG results will only be reported to you if they are *abnormal*. If your results are within normal limits you will not be notified.

Which Pharmacy do you use? Name:

City: State:

Patient Signature Date Physician Signature Date

Patient Signature Date Physician Signature Date

Revised ~~1/5/18~~, 3/30/18 wt